NEBRASKA WEST NILE VIRUS CASE REPORT FORM

The Nebraska Health and Human Services System have been notified by a laboratory that your patient has tested positive for West Nile virus. We collect demographic, clinical and risk factor information on all positive individuals to characterize the epidemic. This investigation is allowed under HIPAA for public health purposes. **Please return this form within one week** and contact us with any questions at (402) 471-0935 or (402) 471-6450.

Please Forward Report to:

Nebraska Health & Human Services
Office of Epidemiology

Phone: (402) 471-0935
FAX: (402) 471-3601

Reporting Agency:

Reporter: _____ **Facility:** _____
Phone: _____ **FAX:** _____
Investigation start **Date:** _____ Form completed **Date:** _____

PATIENT DEMOGRAPHICS

Last Name	**First Name**	**Home Phone**	**Date of Birth**	**Age** ☐ Years ☐ Months ☐ Days

Address (Or nearest intersection)	**City**	**State**	**Zip Code**	**Census Tract** (Optional)

Sex ☐ Male ☐ Female ☐ Unknown

Race ☐ American Indian/Alaskan ☐ Asian/Pacific Islander ☐ Black ☐ White ☐ Other ☐ Unknown

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

CLINICAL INFORMATION

Signs and Symptoms ▶ Date of disease onset _____

Fever ≥100 °F	☐ Yes	☐ No	☐ UNK
Altered mental status	☐ Yes	☐ No	☐ UNK
Headache	☐ Yes	☐ No	☐ UNK
Stiff neck/Meningeal signs	☐ Yes	☐ No	☐ UNK
Seizures	☐ Yes	☐ No	☐ UNK
Muscle weakness	☐ Yes	☐ No	☐ UNK
Rash	☐ Yes	☐ No	☐ UNK
Muscle pain	☐ Yes	☐ No	☐ UNK
Other symptoms ▶ _____	☐ Yes	☐ No	☐ UNK

▶ **Was patient hospitalized?** ☐ Yes ☐ No ☐ UNK
▶ Date of Admission: _____ Name of Hospital: _____
▶ Date of discharge: _____
Did patient die? ▶ ☐ Yes ☐ No ☐ UNK
If died, date of death: _____
Was autopsy done? ▶ ☐ Yes ☐ No ☐ UNK

▶ **Healthcare provider**
Primary physician _____ Phone _____
Attending physician _____ Phone _____
Attending RN / ICP _____ Phone _____

DIAGNOSIS

*If diagnosis is **encephalitis** or **meningitis**, please indicate basis for diagnosis below:* ▶ ☐ Encephalitis ☐ Meningitis ☐ WNV Fever ☐ AFP (Acute Flaccid Paralysis) ☐ Other _____

Spinal Tap **(CSF)**	☐ Yes	☐ No	☐ UNK	▶ If yes, test date: _____	Results: ▶	CSF Protein _____	CSF Glucose _____	CSF WBC _____
Computerized Tomography **(CT)**	☐ Yes	☐ No	☐ UNK	▶ If yes, test date: _____	Results: ▶	☐ Abnormal	☐ Normal	☐ UNK
Magnetic Resonance Imaging **(MRI)**	☐ Yes	☐ No	☐ UNK	▶ If yes, test date: _____	Results: ▶	☐ Abnormal	☐ Normal	☐ UNK
Electroencephalogram **(EEG)**	☐ Yes	☐ No	☐ UNK	▶ If yes, test date: _____	Results: ▶	☐ Abnormal	☐ Normal	☐ UNK
Electromyogram **(EMG)**	☐ Yes	☐ No	☐ UNK	▶ If yes, test date: _____	Results: ▶	☐ Abnormal	☐ Normal	☐ UNK

WNV TEST RESULTS

Specimen Type	**Test Type** C-ELISA IgM	C-ELISA IgG	**NHHS USE ONLY** MIA	**NHHS USE ONLY** PRNT	**Collection Date**	**Results** Quantitative IgM	Quantitative IgG	Qualitative Positive	Qualitative Negative	Qualitative Equivocal	Qualitative, other	**Test Laboratory**
CSF[1]	☐	☐	☐	☐				☐	☐	☐		
CSF[2]	☐	☐	☐	☐				☐	☐	☐		
Serum[1]	☐	☐	☐	☐				☐	☐	☐		
Serum[2]	☐	☐	☐	☐				☐	☐	☐		

RISK FACTOR INFORMATION **(4 weeks prior to onset of symptoms)**

–	Frequency of insect repellant use	☐ Always	☐ Sometimes	☐ Never	–	Laboratory acquired	☐ Yes	☐ No ☐ UNK
–	Non-laboratory occupationally acquired	☐ Yes	☐ No	☐ UNK	–	Breastfed infant	☐ Yes	☐ No ☐ UNK
–	Breastfeeding mother	☐ Yes	☐ No	☐ UNK	–	Infected in utero	☐ Yes	☐ No ☐ UNK
–	Pregnant	☐ Yes	☐ No	☐ UNK	▶ If yes, due date: _____			
–	Prior West Nile infection	☐ Yes	☐ No	☐ UNK	▶ If yes, what year? _____			
–	Compromised immune system	☐ Yes	☐ No	☐ UNK	▶ If yes, describe: _____			
–	Travel	☐ Yes	☐ No	☐ UNK	▶ If yes, where? _____			
–	Organ transplant	☐ Yes	☐ No	☐ UNK	▶ If yes, date: _____	▶ Facility _____		
–	Blood transfusion	☐ Yes	☐ No	☐ UNK	▶ If yes, date: _____	▶ Facility _____		
–	Blood donor	☐ Yes	☐ No	☐ UNK	▶ If yes, date: _____	▶ Facility _____		